March 2010

West Virginia Bureau for Public Health
Your Health Your Safety Our Purpose
Department of Health & Human Resources

Mumps

Specimens Submission Form

Please complete all of the following information on the patient:

Patient Last Name, First Name		Parent/Guardian Last Name, First Name		
Patient address		City	State	Zip code
Patient County	Patient home phone		Patient other phone	
Patient date of birth	Gender (circle one) Male Female			

When did the patient first become ill? _____

Did the patient have any of the following syndromes?
(Check all that apply)

- ☐ parotitis
- ☐ deafness
- ☐ meningitis
- ☐ orchitis
- ☐ other complication; specify: _____

Was the patient hospitalized? (circle one):

Yes No

If yes, where was the patient hospitalized? _____

Please indicate date of collection for all samples submitted for testing:

Sample	Date of Collection
Serum for Mumps serology (IgM, IgG)	
Buccal swab	
Nasopharyngeal swab	
Urine	

Referring physician or hospital information: (Where results should be sent)

Clinic or hospital name		
Physician Last Name	Physician First Name	
Clinic or Hospital address		
City	State	Zip code
Phone	Fax	

Submit form and specimens to: Attn: Linda Minnich
Virology Laboratory
Charleston Area Medical Center, Memorial Division
3200 MacCorkle Ave. SE
Charleston, WV 25304
Phone: 304-388-4308

Division of Infectious Disease Epidemiology

350 Capitol St, Room 125, Charleston WV 25301-3715
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